VERBATIM PROCEEDINGS

CONNECTICUT HEALTH INSURANCE EXCHANGE

HEALTH PLAN BENEFITS AND QUALIFICATIONS ADVISORY COMMITTEE MEETING

APRIL 11, 2012

DEPARTMENT OF PUBLIC HEALTH
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. . .Verbatim proceedings of a meeting before the Connecticut Health Insurance Exchange, Health Plan Benefits and Qualifications Advisory Committee Meeting, held at the Department of Public Health, 470 Capitol Avenue, Hartford, Connecticut, on April 11, 2012 at 9:00 a.m. . . .

MS. TIA CINTRON: Welcome, and thank you in advance for your help with this effort and for your continued dedication to Exchange development. We are really looking forward to working closely with you in the coming months leading towards State certification.

My name is Tia Cintron. I'm the acting CEO of the Connecticut Insurance Exchange, and maybe we can start with some introductions.

MS. NELLIE O'GARA: So I'm Nellie O'Gara. I'm going to be your facilitator today. By way of background, I was part of the facilitation of the original stakeholder meetings about a year ago, so some of you I've met before.

MR. BOB CAREY: And I'm Bob Carey. I'm a consultant to the Connecticut Exchange. My background is

I was the Director of Policy and Development for the Mass. Connector Authority, and, for the last couple of years, I've been working with a number of states as they implement health reform.

I've been working with Connecticut for six to eight months on a variety of topics.

MS. CINTRON: Could you elaborate a little bit more on your background, though, and why you're involved with this specific Committee? Not to put you on the spot.

MR. CAREY: Sure. So at the Connector Authority, I was responsible for the design of what's considered minimum coverage, which translates into the essential health benefits, so, in Massachusetts, as some of you probably know, there's an individual mandate, and people are required to have a minimum level of coverage.

That was not prescribed by the law in Massachusetts. That was deferred to the Connector Authority Board, and I was the lead staff person, who handled that.

My background really is as a purchaser of health benefits. I worked for a number of years for the State Employees Group Insurance Commission in Massachusetts, which covers about 350,000 people, and,

so, I've handled all of the procurement of the health and welfare benefits for State employees and retirees.

And, so, in particular, my sort of qualifications are that I understand the individual and small group market, particularly as it relates to the minimum standards and the law with regard to actuarial value and the essential health benefits.

I'm also working with the federal government as it sets up what's considered what they call federally-facilitated Exchanges, so as some of you may know, in those states that aren't moving forward and that won't be ready, or are unlikely to be ready, in October of 2013 the federal government will come in and run those Exchanges, and, so, the feds are sort of going through a similar process as this in figuring out, okay, you know, what's the benefit package look like, and how do we enroll people, and, you know, essentially setting up 40 or 30 or 40 federally-facilitated Exchanges potentially, so I'm doing a little work with them, as well.

MS. MARY ELLEN BREAULT: Mary Ellen Breault. I'm the Director of the Life and Health Division at the Insurance Department. I've been at the Department for 20 years, and, before that, I worked in the health field at Travelers as a Pricing Actuary, and

I've been working with the Exchange for some time now doing various projects, and our division is responsible for approving all the forms and rates in the State of Connecticut, and we keep up with the legislation, and I'm kind of for the Department making, just kind of coordinating the efforts with our various divisions on different aspects of the Exchange.

MR. STEVE FRAYNE: Steve Frayne. I'm the Senior Vice President of the Health Policy at the Hospital Association.

MS. JENNIFER JAFF: I'm Jennifer Jaff. I'm the Executive Director of Advocacy for Patients with Chronic Illness.

MS. MARY FOX: I'm Mary Fox. I'm retired from Aetna two and a half years. My most recent responsibilities there were product design, development, innovation, as well as P and L responsibility for the operations for those products.

DR. ROBERT McLEAN: I'm Robert McLean. I'm a Primary Care Internist and Rheumatologist in New Haven. I'm here, because I'm very active in the State Medical Society, largely through my role as Governor of the Connecticut Chapter of the American College of Physicians, where I'm involved in a lot of their National

Health Policy Initiatives for the last decade.

MS. DEIRDRE HARDRICK: I'm Deirdre Hardrick, and I am a Program Manager at Aetna in the Exchange Project Management Office. My background is public health, health policy, as well as provider contracting --

MS. GLORIA POWELL: I'm Gloria Powell. I'm a Nurse Consultant for the Department of Public Health. I work in the Comprehensive Cancer Program, where I oversee Quality Assurance, Case Management, Professional Development.

MS. ANNE MELISSA DOWLING: I'm Anne Melissa Dowling, and I'm the Deputy Commissioner of Insurance for the State, and, prior to that, my career was in investments and insurance with Mass. Mutual, Travelers and Aetna, and I am the Department's member on the Exchange Board.

MR. BOB TESSIER: I'm Bob Tessier. Along with Mary and Melissa, I'm a member of the Board of Directors of the Exchange. I'm also the Executive Director of the Connecticut Coalition of Taft-Hartley Health Funds, which is a coalition of Union management-sponsored, self-funded, self-insured health plans.

MR. JOSEPH TREADWELL: Hi, I'm Joe

Treadwell. I'm the Legislative Chair of the Connecticut Advisory Association. I serve as the Director of the Yale Surgical Residency Program, and I'm the Director of the Joslin Diabetes Center, so my background is in chronic illnesses.

MS. MARGHERITA GIULIANO: And I'm Marty Giuliano. I'm the Executive Vice President of the Connecticut Pharmacists Association, and I'm a Pharmacist, as well.

MS. CINTRON: Thank you very much, again, and welcome. I want to just go over a few logistics, and then I'm going to be turning it over to our facilitator and our subject matter expert, Bob.

We want to talk a little bit about the focus of this Committee today, go through a draft of guiding principles for discussion and review. We want to look at in detail the priority tasks for this Committee, again, gearing towards our end goal at the end of this year, State certification, and then talk about Next Steps, and we'll also have 15 minutes, as appropriate, for public comment at the end of this meeting.

So, with that, we are, again, really kind of singularly focused for the next nine months on State certification, which is an operational, comprehensive

operational overview of our business operations and IT-related system functions for the Exchange, so, in the next few months, we go through a series of three formal gate reviews, as they're called in D.C., where we look at planning design and implementation.

We just went through our first pre-planning review in D.C. last week and successfully talked through approach and kind of our thoughts, in terms of Next Steps, so we have a lot to accomplish, and, as you know, these four Advisory Committees were developed to focus in on this nine-month period primarily to achieve all of the objectives that we need to successfully apply and go through certification.

We know that each of these Committees will be very integrally related and need to be cross-walked, so Bob will be talking about that matrix and how we're going to all work together.

So we have kind of outlined by month the tasks that this group will need to consider and make some decisions around, and, again, Bob will be walking us through that today.

Just to give you a visual, every month, there's going to be some work that we need to address collectively. Anything else? So, with that, Bob, I'll

turn it over to you.

MR. CAREY: Okay, so, as you know, there are four Advisory Committees that we established, and we tried to delineate each Advisory Committee's responsibilities, but there's overlap across each of those Advisory Committees, so, yesterday, we met with the Brokers, Agents and Navigators Advisory Committee and with the Consumer Experience and Outreach Advisory Committee, so there are responsibilities in each of those Advisory Committees that will likely be affected by the work of this Advisory Committee.

So, for example, you all are responsible for recommending the Essential Health Benefits Package that will apply not only to the Exchange, but to the broader individual and small group market, and that's a decision that is not just the Exchange's to make, but the Exchange Board and this Committee has a role to play in evaluating the options and recommending what the Essential Health Benefits Package will look like for the Connecticut marketplace.

That also has an effect, we think, on the Consumer Experience and Outreach Advisory Committee, so the way that we have structured the recommending and reporting out is that, for example, with the essential

health benefits, this Advisory Committee will review the options and will prepare a recommendation.

That will, then, go to the Consumer Experience and Outreach Advisory Committee for them to review and to comment on, and will then be brought to the Board, so we think that there's necessity to coordinate activities across these Advisory Committees, so there's a number of ways in which we'll do that.

One is that the meetings are open to the public, the information is posted publicly, and Advisory Committee members of various Advisory Committees can sit in and monitor or just understand what's happening within each of the Advisory Committees.

The second way in which we'll be able hopefully to coordinate the activities of the Advisory Committees is that the Board co-Chairs of each Advisory Committee will report each Board meeting to the broader Board about what the Advisory Committee has been doing to just inform the rest of the Board and to allow feedback and discussion amongst Board members, so we think that's an opportunity for understanding what's happening and the path that will be taken by each of the Advisory Committees.

The second way in which we are hopeful

that there will be some common approach to these issues is that we're going to walk through draft guiding principles, and, so, we put together these draft principles for each Committee.

They're slightly different for each Committee, because each Committee is responsible for different aspects of the Exchange, but we think that that common framework and sort of a manner by which you can make decisions that use the guiding principles as a check against your approach will be helpful, we think, in minimizing any conflicting recommendations that may come out.

So, for example, this Advisory Committee is responsible for making recommendations on the numbers and types of health plans that will be offered through the Exchange, and the Consumer Experience and Outreach Advisory Committee may have an opinion on that, in terms of how many plans should be offered, and what the Consumer Experience looked like, and, so, we want to make sure that there's some common guiding principles across Advisory Committees, and we think that that will be an important way in which we can insure that there's a minimum amount of conflict amongst the Advisory Committees.

And, so, we're going to go through, and the discussion yesterday in both of the Advisory Committees really got down into some specific details about what do you mean by, you know, each of these guiding principles?

And these, again, are drafts. These are suggestions that we put together. We welcome additional guiding principles that you may have, and you certainly will, you know, beat up each one of the principles that we put together, so those are sort of the three ways we think we'll be able to manage the process as we move forward.

We do have some tight deadlines. For example, the Essential Health Benefits Package. In order for health plans to offer products that will be offered in October of 2013, we need to make decisions in 2012 about what the Essential Health Benefits Package looks like, how many plans are we going to offer, what's the structure of those plans, so, you know, January 2014 may seem, you know, a long way off. It's not, particularly for health insurers, who have developed products that meet the requirements that we're going to set.

For those of you, who weren't familiar with the way in which health plans are developed, it's

not an overnight process, and it takes time to put together a benefits package that's consistent with whatever requirements we put forward.

I think that folks around the table understand that. I just want to emphasize that, in terms of the necessity to move pretty quickly through some of these issues and make decisions and move forward.

The other thing I'll just say, in closing, on sort of guiding principles and Committee overlap is that, you know, the Exchange in 2014 will look very different than the Exchange in 2016, and it will look different than the Exchange hopefully in 2018, and it's not a one-off deal, and there will be ways in which you'll be able to refine decisions.

So while we have to make decisions in 2012 for 2014, it's not the end of the game, and we'll learn from the mistakes that we make in 2012 as they affect 2014 and be able to modify things as we move forward, so just this isn't the end of the discussion, but we do think that time is of the essence, and we need to move forward pretty quickly.

I don't know if folks have any questions about that. There was a recommendation at one of the Advisory Committees that there be a designated person

from that Advisory Committee, who serves as a liaison to each of the four Advisory Committees. I don't know if that's something that this Advisory Committee may want to formalize or not, but that was just a recommendation I just wanted to share with the group.

MS. O'GARA: Okay. Any comments or questions of Bob or Tia as we get started? Okay. A couple of sort of operational items. We are recording this session, so I am Nellie O'Gara going on record, and when you speak, if you'd say your name? Sometimes I'll say it, take care of it for you. The other thing is the bathrooms are on the other side of the soda machine.

Finally, we have been working with the other Committees in a suggested way, that when we are looking at documents for review and comment, we will try to reflect the majority support, the consensus of the group, but when you're making recommendations, we will go to a formal vote, so we have a record of those pro and those against, okay?

Having said that, if we could put up the principles here? The first one, what we want to do is get your perspective on what we've suggested for your consideration.

You may want to modify these. You may

want to add to them. So we'll go through each one, one-by-one, and I'll ask for your perspectives. The first one has to do with affordability. Affordability is a (feedback) and is essential to the ability of Connecticut residents to retain and maintain access to health care and health insurance. So that's one of the guiding principles we're suggesting.

Is that meaningful to you? Dr. McLean, you're saying yes?

DR. McLEAN: Yes, very much so. Good number one.

MS. O'GARA: Good number one? Anyone else want to weigh in on that? Bob?

MR. TESSIER: Agreed.

MS. O'GARA: Jennifer?

MS. JAFF: My concern would be that placing affordability above all other goals, I'm concerned about the other goals getting kind of lost in this.

I'm also on the Consumer Outreach and Experience Committee, and one of the issues that a consumer brought up yesterday is affordability, so it's absolutely essential for consumers, and we don't in any way dispute the importance of affordability, but there

are other concerns, like adequate coverage and adequate network, provider networks and so on.

So my only concern is that this appears to place affordability above all else, rather than on the kind of same line as other very important goals, like coverage of as many people, who are uninsured, as possible and so on.

MS. O'GARA: I'm not sure we were suggesting an order, so you can --

MS. JAFF: No. It's the paramount.

MS. O'GARA: Okay. Mary?

MS. FOX: I would echo Jennifer's concern, that maybe the number one priority should be the consumer experience and that the needs are met, affordability being one of the critical ones, but, you know, addressing a number of the other principles, which we see already, and some, which I think will come up in the discussion.

MS. O'GARA: Are you suggesting, Jennifer, we choose another word in front of importance?

MS. JAFF: Yeah. I mean I think to say it's of great importance would certainly be accurate, and that would reflect the consumer experience, certainly.

MS. O'GARA: Okay. I'm sorry. Bob McLean?

DR. McLEAN: Yeah. I would have to differ. I think, if someone can't afford it, it's a moot point, so if they're not able to get it, because they can't afford it, the rest of it is irrelevant, so I think, quite frankly, it is of paramount importance, because, otherwise, they're not even getting -- they're not getting it.

MS. O'GARA: Deirdre, you would like?

MS. HARDRICK: And I would say that (indiscernible - too far from microphone) maintain, but I think we should have obtain.

MS. O'GARA: Obtain?

MS. HARDRICK: Obtain for consideration.

MS. O'GARA: What about the -- the public comment will come.

MS. MARIA DIAZ: Pardon me. (Indiscernible - too far from microphone)

MS. O'GARA: We want you up here. There's another seat here.

MS. DIAZ: Maria Diaz.

MS. O'GARA: Thank you. All right, so, we have a couple of comments here, suggesting that we consider changing the word paramount to great, that we add the word obtain, and that this is still of

importance.

So why don't we put this as I revised it, and we can come back to it and see if we've hit on all the other items that are important, too. Is that all right with everybody?

The second guiding principle that's suggested is the Exchange should offer consumers meaningful choice of high-value qualified health plans that meet the diverse needs of Connecticut residents and businesses. So a couple of items there are choice, high-value qualified health plans, and both for Connecticut residents and businesses.

DR. McLEAN: I think those are all kind of phrased to that particular need in this environment, so they're appropriate to be there, so I think that states it well.

MS. O'GARA: And that was Bob McLean. And Jennifer?

MS. JAFF: Just do we want to say small businesses, as opposed to businesses, since the Exchange won't, at least to start out with, will only be dealing with small businesses?

MS. O'GARA: Has that been decided?

MR. TESSIER: It's the law. It is the

law.

MS. JAFF: It's a given.

MS. O'GARA: So what's the feeling of the group? Are we adding small? There's a no there.

MR. TREADWELL: I think it's more accurate to say small. I agree with that.

MR. TESSIER: One option is it's going to be a fluid document over the years. We're not allowed to be fluid, and businesses can incorporate whatever the law needs. It doesn't supersede the law. It just follows the law, so if you use businesses, you're just going to have to change the guiding principle in three years to say, okay, now it's going to be 150, so that can follow with small businesses nationally, change the law.

MS. O'GARA: What's the consensus of the group on that? Leave it as businesses? I'm seeing four or five heads shaking yes. Six.

All right, the third item is on competition. The Exchange should promote competition among health insurers, based on price, quality and service. Yes?

MS. DOWLING: Anne Melissa Dowling. I think this is critical to make sure we have enough carriers participating, so that it doesn't get lopsided

and we're limited, so we have to make sure that we create an environment through the Exchange and at the State that allows competition.

MS. O'GARA: Do we say it in here in a good way on this particular one?

MS. DOWLING: I think so. I mean the word promote can be a little bit loaded. We want to be careful, but I think should encourage, support, whatever.

MS. O'GARA: Okay. We could change that word to encourage and support.

DR. McLEAN: May I?

MS. O'GARA: I'm going to take Mary, and then we'll come to you, Bob.

MS. FOX: I would just like to see something about supporting innovation, as well. I think the Exchange has an opportunity to really move forward, in terms of supporting delivery of quality health care and as the providers move forward and change their paradigm for delivery of care, more focused on chronic disease management, on wellness, all the things that, you know, are kind of underway. Now we want the flexibility and I think a real driver around pushing the plans to support that kind of progress.

MS. O'GARA: Mary, I'm going to ask if you

could hold back and go to the last principle. We can put that in there until we talk about --

MS. FOX: -- innovation there.

MS. O'GARA: Yeah, put innovation in.

DR. McLEAN: I agree, too, with what she said. I think that a lot of what she's referring to is encompassed in that high-value qualified health plans in number two. I agree with stating it wherever possible, but I think that high-value qualified health plans has very specific meaning, at least in a provider community, right now.

MS. O'GARA: Do we want to explain that in this particular principle by putting some --

DR. McLEAN: I don't think you want to add that.

MS. O'GARA: Okay.

DR. McLEAN: It's broad enough.

MS. O'GARA: Well let's not lose Mary's comment, and see if you think in the last one we can emphasize that.

DR. McLEAN: I think an initiative in the last -- innovation or something in that last recommendation of principles.

MS. O'GARA: Okay. Jennifer?

MS. JAFF: I'm kind of not sure where the consumer comes into this guideline. Do we mean quality of insurance coverage, or quality of health care, and service to consumers, or service to plans? I think it would be helpful if we fleshed out those two words a little bit, quality and service.

MS. O'GARA: So I'm going to ask Bob. When you were putting this draft together, were you thinking more on the insurance side, the health insurance side?

MR. CAREY: Well what I was trying to do was to, with these price, quality and service, was to move away from, you know, risk selection, or any other ways in which insurers can compete and, rather, allow the consumer to choose from amongst plans that are competing, based on the quality of the service they provide and the types of services they provide and price, which I think are of paramount importance, and, so, that's sort of the concept of an Exchange, is to allow for, you know, a level playing field within which or upon which health insurers compete for customers by offering, you know, high-quality plans that provide good service to the consumer and that are competitive, based on price.

MS. O'GARA: So can we just wait until

these gentlemen can come and join us?

MR. MARK ESPINOSA: I hope the formation of the Committee is better than the directions.

MS. O'GARA: I apologize.

MR. ESPINOSA: I was in the Capitol building. We were at Room 310. Sorry we're late.

MS. O'GARA: And who is joining us?

MR. ESPINOSA: My name is Mark Espinosa.

MS. O'GARA: Hi, Mark.

MR. KEVIN GALVIN: And I'm Kevin Galvin.

MS. O'GARA: Okay, so, you can come around this way. We'd be happy to wait. There's a chair right here, and then maybe, Mark, you can pull up a chair there next to Jennifer. That would be great.

We've just begun discussing the guiding principles, and we're working our way through this third one here. What's been suggested is that we change one word so far. The Exchange should encourage and support competition among health insurers, based on price, quality and service. Yes?

MR. TESSIER: Bob Tessier. I just have a couple of comments. It sounds like, to go back to Jennifer's question, it sounds like, Bob, we're talking about consumer or customer service, so it might be

helpful to clarify that.

MS. O'GARA: Okay.

MR. TESSIER: And the other comment I wanted to make, and I'm trying to figure out whether we can incorporate or combine this thought with Mary's suggestion earlier, I like the way it's drafted. I think it's simple and direct, and it's important that we are clear that one of the guiding principles is that we want to promote competition among insurers for the benefit of consumers.

What I want to add is, in addition to price, quality and service, whether, or throw out for discussion, is whether we can add problems, and I think what I'm thinking of is that that would mean competition among innovative products along the lines of what Mary described earlier, so I'm wondering if that's a helpful thing to add.

MS. O'GARA: Interesting. Okay, so, what we could do with that, to capture your thought, Bob, I have the Exchange should encourage and support competition among health insurers to benefit, to the benefit of consumers, based on price, quality, service and innovative products.

And I'm going to go to Steve and then to

Bob. Steve?

MR. FRAYNE: Steve Frayne. I'm not sure that's accurate. I think it's (papers on microphone) I'm not sure it's accurate what's written on this one, and that is I'm assuming the purpose of the competition among the price, quality and service is so that consumers actually have the ability to choose, based on those parameters, but, as it's written right now, it doesn't actually say that you're going to make the information available.

So it doesn't say right here you make meaningful information available, so that consumers can actually choose, based on price, quality. To just have insurers compete on that basis is kind of fine, but if no one actually has access to the meaningful information and that they can personally decide that, you know, how these things come together, that would be a problem.

MS. O'GARA: Do we need to add that as a specific principle?

MR. FRAYNE: I don't know if you want to have it as a separate principle, or just to incorporate it into it, something along the lines of to promote competition among health insurers and make available information, so that consumers can choose, based on

price, quality and service.

I mean it seems to me the essential ingredient is that information is available, so consumers can choose, not the fact that they're competing.

MS. DOWLING: Do you think that it's covered in the second bullet? We were just chatting over here, whether maybe that was the place to offer meaningful choice. Maybe there's a way to get it there.

MR. FRAYNE: Well I think the question I have in my mind is whether folks review this as the insurers have to decide that they're competing amongst themselves, so that's kind of enough, versus how do people, who are actually looking at this, know, and I think we wanted to make sure that it's not only the competition, but that it's publicly available information.

MR. TESSIER: I actually think that's an important distinction, and I have been thinking of it as a separate issue and was thinking about how we want to be clear, and, Bob, you may have previous experience with this in Massachusetts, how one of the things that makes insurance, health insurance so confusing for consumers is just the volume of information and sorting it through, and how does one product, one plan compare to another, so

how do we provide?

It goes to the word Anne Melissa focused on, meaningful access, or meaningful choice. I tend to think that it's even a separate and bigger issue, but I agree with the basic point that you're making, Steve.

MS. O'GARA: So we have a couple of options. Yesterday at the meeting you were at, Jennifer, we had a principle that got out a lot of what you thought of, but it did not reflect that the information was going to be provided, so, therefore, they could make a choice, so if what we could do, Steve, if you don't want it as a separate one --

MR. FRAYNE: I think maybe a separate is fine. We could make this an extraordinarily long list, and then it becomes so tedious, so I'm fine with adding it as a separate issue, if that's a cleaner way to do it.

MS. O'GARA: Okay.

MR. FRAYNE: I just think making sure it's public information is essential.

MS. O'GARA: So we could say the Exchange should make available meaningful information, so consumers can --

A MALE VOICE: Meaningful, understandable information.

MS. O'GARA: Yeah. Well, actually, they have -- the group had a very good guiding principle. If you want to incorporate theirs, I can read it to you. Okay. Let me go back.

Consumers should be provided information on, meaningful information on outreach, pre and post-enrollment and coverage options that is understandable and accessible in multiple formats.

For example, we talked about internet website, telephonic, sign language, and in multiple languages. That's one.

Then we went on to a number of different ones, so there's about six that they pad with consumer information, but we didn't have this particular one on meaningful information to make a choice, so I'm happy to craft something for your consideration at the next meeting that gets out there, if you'd like us to do that.

DR. McLEAN: I don't see how that adds anything to what it already states. Offer consumers meaningful choice. They have to be educated to make a meaningful choice, to kind of circling around and saying -- is already written there, I think.

MR. FRAYNE: The reason I was making this statement, maybe the analogy I'm using was, for example,

hospitals think that they compete every day on price, quality and service. There's a huge difference when that information is then made public and is reported, so that others can actually decide for themselves whether or not they're meeting the test of price, service and quality, so I think they really are two very different things.

MS. O'GARA: So what if we did this, Steve? What if we did add to that second bullet the Exchange should make available meaningful information to consumers, so that they can make an educated choice between high-value quality health plans, da, da, da, da, da.

MR. TREADWELL: In a simplified way?

MS. O'GARA: In a simplified way. I mean I'll simplify it, okay?

MR. TREADWELL: Two or three points. Make it like two sentences.

MS. O'GARA: Well let's see if we can do that.

MR. TREADWELL: I like his idea on making it a separate point, because once you start --

MS. O'GARA: Yeah.

MR. TREADWELL: -- paragraph for a principle. Make a separate bullet and move on.

MS. O'GARA: Okay. Jennifer, one more comment?

MS. JAFF: Yeah. I think it's really important, actually, to make it a separate bullet, I think because these guiding principles kind of all start with the Exchange should, and, so, this is a place where we can say that the provision of information to consumers is one of the main tasks of the Exchange, the main purpose of the Exchange, which it is, so I think it deserves its own bullet.

MS. O'GARA: Okay. All right, I'll bring it back to you for your consideration. Then the next two, the Exchange should offer qualified health plans that allow consumers to receive care for diverse networks of physicians, hospitals and other health care providers, including providers that served underserved areas in the State.

Can I hear from some people that we haven't heard from? Let's hear reaction to that. Is it meaningful the way it's stated? Yes?

MS. DOWLING: I'm Anne Melissa Dowling. I'm interested in the thinking when the Exchange is going to serve the entire state. What was in forming that last clause that we need to break out the underserved areas?

Is there a reason we need to break that out versus suggesting that up in the beginning we say to all areas of the State, but there might have been something behind this I just didn't know about?

MR. CAREY: Yeah. The intent of that is to get at the requirement under the federal rules, that provider networks include essential community providers, which are providers that serve maybe areas is not the proper term. It could be populations or groups.

It's really getting at those individuals in populations that have maybe not historically, but more recently been less served, in terms of their access to providers, so it's getting at really the essential community providers that I was saying, because then you'll have to define, well, what do you mean by essential community providers, so I think maybe underserved, or groups, or populations might be better than areas.

MS. DOWLING: Thank you.

MS. O'GARA: So could we change that to underserved populations?

MR. CAREY: That's the intent.

MS. O'GARA: Would that be better? I have three comments back here. Mary, I think you had your

hand up?

MS. FOX: I think that, if you play this out, in terms of being able to measure the impact of the Exchange, I think the intent here, I hope, is to get at things like disparities in health care, so the underserved areas are going to get special focus here. They haven't been served by, you know, the commercial market.

I think it's very important. It's less important exactly how it's said, just that we do follow through on the impact piece of that.

MS. O'GARA: Okay.

MS. FOX: The other thing is -- I'll leave it at that.

MS. O'GARA: Steve?

MR. FRAYNE: Steve Frayne speaking. I'm not sure what you're intending by the word diverse. I mean it seems to me that the standard has to be some level of access and whether one wants to define it as reasonable access, or adequate access, or robust access.

Diverse, to me, seems like kind of a strange way to describe the collection of folks that you'd want to have in the network.

MS. O'GARA: -- at some other piece, Bob?

MR. CAREY: Yeah. Anne is trying to get this issue of, you know, providers that may serve a particular population, and that, I think, is what I'm trying to capture. The focus is that the provider networks need to be represented about the populations that they'll serve, or represented -- need to be appropriate for the populations that they will serve and will have access in those communities to providers.

COURT REPORTER: One moment, please.

MS. FOX: Quality into that statement, also, and it's diversified, but I think that's critical, also. And if we're looking at affordability and managing all that, I think the focus on quality is going to be important.

MS. JAFF: I agree with changing underserved areas to underserved populations. I think that's a broader focus, so that was one of my points, and with respect to the diverse networks, I don't have a problem with the word diverse, but I absolutely agree with Steve, that what's really critical here is the adequacy of the network, and I think quality is obviously also terribly important, so perhaps we can take diverse, quality and adequate networks, something along that line, both lines.

MS. O'GARA: Okay. We can put those in. Thank you. Dr. McLean?

DR. McLEAN: Robert McLean. While I think the meaning of underserved is actually meant to be broad, while I do agree that population is probably one of the intent there, I think especially the parts of our state that are relatively underserved, I think having a geographic area has some implication that probably warrants it, so a population and geographic area I think is what you both are aiming to and I think is important for especially the eastern part of the state that is geographically underserved.

MS. O'GARA: We can add that. Anything else? Joe?

MR. TREADWELL: Joe Treadwell. I guess I'm just finding it difficult to understand. I get the intent. I'd almost rather get rid of receive care from a diverse access, receive care from diverse networks and have consumers to have ready access to physicians, hospital and other health care providers, including in the underserved areas.

To me, what it's really trying to get to is the access. Who cares if you've got a lot of physicians in an area? If they're not on that plan, you

don't have access. That's never the problem. There's always a physician in the areas, but do you have access to that physician?

MS. O'GARA: Let me read back to you how this might incorporate a number of -- let's see if it doesn't get too wordy, okay?

The Exchange should offer qualified health plans that allow consumers to have ready access to diverse, quality, adequate networks of physicians, hospitals and other health care providers, including providers that serve underserved populations and geographic areas.

MR. TREADWELL: I don't even know if you need the diverse networks, because I think it's kind of assumed that, when you say the word physicians, you have multiple specialties, including underserved providers that serve underserved areas.

We're not looking for providers that will serve an underserved area. I would rather see providers within that geographic area. I have people come up to New Britain from Bridgeport, New Haven, all of the eastern side of the state. I'm not easily accessible to them, but I'm the only one who does that type of work for what they need. That's crazy.

MS. O'GARA: What is the feeling? Take out the word diverse?

DR. McLEAN: Robert McLean here. I do think that the diverse network has some warrants and meaning, because while I agree fully with the ready access, I think that's a wonderful phrase to put in there, because that really gets at the meaning, I think that we're trying to direct that the plans have to have both physicians and hospitals of varying sorts across the state, and I think the diverse network gets at how the plan needs to be set up.

It's not just the ready access, which I agree with. It's also we're trying to set out the roadmap of what the plan needs to include, so they have plenty of ready access in one town, but they don't have it somewhere else in the state.

The person happens to get sick somewhere else in the state, it doesn't do them any good. Obviously, I think the health plans are going to have statewide plans, but emphasizing the diversity of their network between physicians and hospitals and specialists and all that I think is worth saying.

MR. ESPINOSA: May I ask a question?

MS. O'GARA: Yes. Mark?

MR. ESPINOSA: Mark Espinosa. I just want to jump way ahead. My question is, with all this wonderful wordsmithing going on, that's fine, how is, just for my own education, how is the consumer going to be instructed and educated down the road when all the wording and the access attempts fall upon deaf ears?

In other words, you know, in my organization, I have 10,000 members in the State of Connecticut, many of whom are young people, under the age of 30. No matter how much I wordsmith insurance letters and pension letters, it inevitably is going to have questions, and we can always sit here and put this word in and put that word in.

So my question is how are questions and issues going to be dealt with down the road? Has that been -- how does someone get the information beyond this, is my question?

MS. O'GARA: We can answer that with a very thoughtful approach. Do you want to take that, Bob, in terms of the Committees and the group that Jennifer is on?

MR. CAREY: Yes. So there's a Consumer Experience and Outreach Advisory Committee, and one of its main responsibilities is to do just that, to help the

Exchange develop information that's understandable to people, many of whom are uninsured, have never been insured, don't understand insurance, so a focus of that Advisory Committee is to do just that, is to help set up the infrastructure that will be necessary to help people, and we went through this exercise yesterday about it, not just pre-enrollment and during enrollment, but post-enrollment, helping people understand how to use insurance, what it covers, what it doesn't cover, how to help them through with any complaints and appeals that they may have, so that's a focus of that Advisory Committee.

And I think, really, a broader focus of the Connecticut Exchange is to help people, again, who will be new to insurance, navigate the insurance marketplace and provide them with the information in an understandable fashion, so that they can maybe form decisions that they can then access the care that is available to them.

MR. ESPINOSA: Is that the intention, or is the setup -- is it going to be a centralized brain center? Are there going to be 800 numbers? Is there going to be e-mail?

MR. CAREY: That's all part of the package

that will be -- we talked yesterday, again, about that the information needs to be made available in multiple formats, meaning web, phone, walk-in center, utilizing brokers and agents, and we had this discussion about navigators, so we recognize that people will need -- people receive and process information differently, and there will be a need to help people in multiple ways to navigate their health insurance options.

MR. ESPINOSA: One final piece. I'm sorry. The open enrollment period I saw from the guidelines last time I heard you speak at the end of '13, so October or whatever it is.

Beyond that period of time, is it a yearly open enrollment? Someone can jump in at any point, or do they have to wait for the next enrollment?

MR. CAREY: Currently, the thinking from Washington is that open enrollment is pretty expansive the first year, so their thinking is October 1st through the end of February, so a five-month period, which people will be able to enroll in coverage.

After that, only for change in status. Now you lost your job. You're newly uninsured. You moved to the State. There are various qualifications or circumstances that would allow someone to access an open

enrollment period or a special enrollment period, but that there be annual open enrollment periods, so perhaps the next October open enrollment again.

MR. ESPINOSA: Thank you.

MS. O'GARA: This is important, I think, as an example of how you can see the interplay between the Committees, and, so, Jennifer, did you want to add a sentence?

MS. JAFF: Did we decide to add another bullet on the Exchange will provide quality information to consumers before Mark got here?

MS. O'GARA: We're going to do a separate.

MS. JAFF: Yeah, that's what I thought, so I think it was right before you got here, but we, I think, agreed that that would be a separate bullet, the information, because that is critical.

MS. O'GARA: Okay. Yes. Margherita?

MS. GIULIANO: I'll just add a clarification. Although pharmacists are recognized as health care providers, I'm wondering if we need to articulate that pharmacy networks might be an additional.

MS. O'GARA: What's the feeling of the group, because -- and I don't want to deemphasize anybody. We have a lot of other providers, as well.

Yes?

DR. McLEAN: This is Robert McLean. I agree fully, actually. I mean I think that, if you're talking about ready access, if someone can't go to a local pharmacy and get the medication they need, that's not ready access, so where more and more plans have understandable contracts with mail aways and stuff, I think somehow having something that they can get what they need when they need it pharmaceutically is logical to include.

I don't know how I'd phrase it, but I agree with putting it in there somewhere.

MS. GIULIANO: Only because it's slightly different. I mean the pharmacists they might have ready access to a pharmacy, but that might not be practicing in a pharmacy either.

MS. O'GARA: I can add that, and, again, you're going to have another take at this next time we're together, so let's see.

And then the last one is stated as the qualified health plans offered through the Exchange should promote wellness and health improvement. Mary, I wanted to invite your comment here and see if this is a place that we could emphasize your concern.

MS. FOX: I do think it's a place we could talk about innovation. My ideas and list of things that could be considered in innovation is going to be way too long for a guided principle, but I would not want to limit it just to the wellness and health, so the fact that we put those in there, you know -- I would love to have, you know, products that, and maybe innovation just covers it, but I would love to have products that, you know, focus on pay for evidence-based care, you know, eliminating waste, paying for quality, coordination of care, disease management.

It could be quite the laundry list, but the point is we need to move the needle as much as we can in our selection of products that really promote the quality care, you know, as well as the access.

MS. O'GARA: So why don't we, for your consideration, say the qualified health plans offered through the Exchange should provide innovative products that include, but are not limited to, wellness, health, and list some of the ones that you came up with?

DR. McLEAN: I agree with the intent. I think most of what you're aiming for is included in that high-value qualified health plans in bullet two. I don't know that you want to mandate in a way innovation,

because then innovation is not going to work, and I think the insurance companies are smart enough to not go out there and do something kind of silly that's not proven anyway, so some of the buzz words that we've used, high-value plans, as I say, incorporates just about everything that you touched on to the people who know what that means, and the wellness and health improvement we clearly need.

Innovation will come, as it's proven to be high-value. And, so, if these companies are going to be making money on health care, they're going to be providing high-value plans, because those are high-quality in their outcomes and all those kinds of things, so I think it's included already.

MS. O'GARA: So I have a couple of hands. Anne Melissa?

MS. DOWLING: I think it's been distributed to all of you, but perhaps not and will be, the guiding principles for the Exchange as a whole, and innovation is a significant one there, so I like the idea of having it tie, some of ours tie to those, which some of these don't already do.

So I feel fairly strongly that we should -- if our goal over the next nine months is to be sitting

here, looking at plan design, benefit design, all of that, it's not just what's offered. It's how the plan is structured, how it's paid. There's a lot of other things here. So I feel that it might be a little too subtle to suggest high value.

I'd like to actually use the word innovation, just because it's a nice partnering to what's matching the overall Exchange, and here's an opportunity for us to push back on some of the offerings to say let's see a little more innovation.

Let's see some other designs. Let's see some different methodology. So that would just be a counter point for me.

MS. O'GARA: Okay and I had some more hands. Margherita and then Joe.

MS. GIULIANO: I'm just wondering if we could, also, instead of just promoting wellness and health improvement, maybe look at promoting the measurement of the health and wellness improvement.

MS. O'GARA: Joe?

MR. TREADWELL: Question for Mary. When you speak of innovation, you're talking about the product, itself, correct?

MS. FOX: Yes.

MR. TREADWELL: So, to me, this last bullet has nothing to do with the product. To me, the bullet that talks about product is the one in the first line, the Exchange promotes competition among health insurers, based on price, quality and service, I think that's where innovation should go. This is talking about wellness and health improvement, the physical well-being of the individual patient, so, to me, I don't think they should be linked together. I think innovation is better off with the product, itself.

And as far as measurement goes, that's a whole different concept. Are you talking about measurement of outcomes and evidence-based medicine? I don't know how that ties in with -- I get it, the importance of it. We need measurements in evidence-based medicine.

I don't know if the insurance company, per se, is -- when we talk about in this bullet wellness and improvement, if that's the place to do it. We definitely need that, because you have access to the data from the database for a chronic illness, but, to me, it doesn't go in that bullet.

MS. O'GARA: Well let's take a couple of the comments one-by-one. I've added innovative products

to the third bullet in the preview.

The question of whether adding it again here, and then, in terms of measurement, you may want to have a separate principle about measurement. There may be other things you want measured, besides --

MR. TREADWELL: Yeah. To me, this third bullet is about let's encourage people to stop smoking. Let's encourage them to take their blood pressure medication, whatever medications they need, so they don't go to the doctor every month.

MS. O'GARA: So help me with that. Let's go back to Mary.

MS. FOX: I agree, except that I don't think there's a distinction, but I was trying to promote the connection between a product design that could support all of these things that are going on in the various provider communities, including pharmacy, individual providers, hospitals.

There's a lot of innovation going on there that is not coordinated, and, in fact, I think has been at odds with the (papers on microphone) have been at odds with each other, either timing, or territorial, or whatever, so what I was trying to work in here was some way for us to think, and, again, as a guided principle,

not a mandate, but some way to think about how do we support all the innovation that's going on in the broad health care marketplace, the delivery.

And there are, in my mind, ways to design products and to work with plans to do that in a very effective way.

And, again, to Bob's earlier comments, it's not going to necessarily happen across every product from the get go, but, as a guiding principle, I think that's really important.

MS. O'GARA: Is there a general feeling that we should include innovations?

MS. JAFF: Yes.

MS. O'GARA: Okay, so, I'll work on that. What about this measurement issue? Should we add the measurement piece to this? Yes?

MR. GALVIN: Hi. Kevin Galvin. I think the measurement component of this is important enough to be a separate line item, because there's so many parts of -- so many things that we could look at for measurement when you're talking about product design.

MS. O'GARA: And what are some of the things that you think would be important to say about measurement?

MR. GALVIN: I'm going to leave that to people, who know the products better than myself.

MS. O'GARA: Okay.

COURT REPORTER: I'm sorry. Could you repeat that?

MR. GALVIN: I'm going to leave that to people, who know more about product design than myself.

MS. O'GARA: What about the sense of the group, in terms of the separate measurement? Joe?

MR. TREADWELL: How do you define measurement? You're talking about outcomes, based off of treatment paradigms? I'm not sure. I wouldn't even put necessarily measurements and guiding principles, because this is about the Health Exchange.

To me, a measurement is about outcome studies and improving the delivery of health care, so maybe that's just something that's down as an offshoot of this. The data would be there if we had access to the insurance websites. I don't know if it's a guiding principle.

Guiding principle to me is about the patient, the delivery of the insurance, the physicians, the networks. I'm just not sure how you consider that a guiding principle. A measurement to me is like from all

this we have the data, and, from there, we can go forward, but I don't know if it's a guiding principle.

MS. O'GARA: Deirdre, did you want to make a comment?

MS. HARDRICK: Just one small comment. As part of the Exchange, in certifying that qualified health plan, they are going to have to review and evaluate data, outcome data, also, consumer satisfaction, so that may be something important we want to incorporate, because we're going to have to I believe maybe annually recertify and look at outcomes or performance.

MS. O'GARA: Let me ask Bob if you want to make a comment.

MR. CAREY: It could tie to the earlier comment, about the information that's provided to the consumer, that certain metrics, as we, you know -- to make an informed decision, part of that may be, you know, outcomes-based metrics, or customer satisfaction surveys and that type of information, so maybe we can incorporate this point about measurement, which is important, but within the context of providing information, so that a consumer can make an informed decision.

MS. O'GARA: Okay.

MR. CAREY: And the other comment is to

Mr. Treadwell's point, about the focus of this was really on the patient, because we talked about what the health plan should do, and what the Exchange should do.

The third party, the most important party in this relationship is the consumer and the individual, and that was my intent when I drafted this, was to turn the focus also onto the consumer about, you know, innovative plan designs that promote wellness and health improvement, as opposed to a pre-paid medical card.

MS. O'GARA: Dr. McLean, and then I'm going to go --

DR. McLEAN: I'm Robert McLean. I agree completely. I think that the idea of reporting measurement to the consumers is kind of what we want to say needs to be done. I don't think that we, as a guiding principle, need to mandate measurement.

Everyone is going to be measuring everything, including the various plans, is this working, so I think it's kind of silly for us to say you should be measuring stuff, but reporting it as a meaningful piece of information to the consumer in a meaningful, easy, simplified way is something that we can state in a useful way.

MR. TREADWELL: Which is wonderful.

Imagine if you were a patient, and you were looking at how many they do for MRIs, CT scans, bone scans, boy, that would be great, but they just randomly -- I'd say that's an easy choice.

MS. O'GARA: Okay. Steve, you had a comment.

MR. FRAYNE: I think the concept here on measurement is, at the Exchange level, is measuring the plan relative to what it said it was intended to provide, not necessarily the quality that the providers are offering, which is a different set of measurements.

I mean, obviously, presumably that's going to occur somewhere, as well, but I think having something, where it says, okay, we told you we had a network. For example, the State of Connecticut has done secret shopper studies on the Medicaid plan and found that, you know, the network was said to be X, and it turned out to be something less than X, so having some sort of reporting regarding, you know, here's what was promised, and did the product actually deliver?

I'm not sure all the places where you would measure it, but it seems to me you should want to -- the Exchange should promote some measurements, some factual measurements regarding the parameters on which

the plan promised to offer certain services, price, quality, etcetera, to the consumers.

MS. O'GARA: Well I'm going to make a suggestion on that, Steve. In the new separate principle that we're going to speak to, the meaningful information, we'll try and elaborate a couple of points on adding some -- the measurement metrics to that.

So what I have now is I've got six principles. We've done a pretty good job of tearing these apart and putting them back together, and I will bring them, with Bob's help, to the next meeting, and you'll have a chance to reflect on them between now and then, okay?

So that will take us, then, to the next piece of the agenda, and I think that's you, Bob.

MR. CAREY: Yeah. So we wanted to walk through sort of the list of responsibilities and the timing for this Advisory Committee.

I will say that your plate is probably more full than the other plates than the other Advisory Committees. We think this one, in particular. This is actually the products that will be offered, and the network adequacy standards, and the essential health benefits and so forth.

We're reminded of the situation in Florida. So Florida has a private Exchange, and if they had products, you could purchase from this private Exchange, but they have a shell, and they have a store, and they have no products, so we need to be mindful of the fact that, you know, it's a voluntary market on behalf of the consumer, but it's also a voluntary market on behalf of the insurer.

Insurers are not required to participate on the Exchange. This is certainly an incentive. There's lots of new customers that hopefully will be coming through the Exchange, but I just wanted to raise that, so if you go to Florida Health Choices, it says, you know, coming soon, but that coming soon sign has been there for a few years, so we need to be mindful of the fact that we need to make it an attractive place for consumers, of course, but, also, attractive and someplace that insurers want to participate on.

DR. McLEAN: Question. This is Robert McLean. So is that store empty, because of excessively restrictive requirements that have come back to the State, or do other issues apply in Florida?

MR. CAREY: No. I think the store is empty, because of the fact that there are other

distribution channels, and the carriers are comfortable with the current distribution channels, and they don't see a need to participate on the Florida Healthy Choices Program.

Utah is another example. They have, you know, I think they have two carriers that participate on Utah's Exchange. There used to be three carriers that participate, but one of the carriers felt that the administrative burdens of participating on the Utah Exchange was such that, you know, they did a cost benefit analysis, and they said you know what? There aren't enough lives in this marketplace for me to spend the time and resources to participate on this extreme.

Just a couple of things to keep in mind as we think about how we're going to structure this Exchange for consumers, recognizing that we need the products to offer to those consumers.

DR. McLEAN: Just one other question. Have other states mandated that the insurer has to, could be eligible to -- state employees have to be in the Exchange?

MR. CAREY: No. There's certainly been talk. There's been considered at the legislative level, about what types of requirements you're going to impose

on carriers, but, to date, there's been none.

DR. McLEAN: Well, in other states, they would make a requirement.

MR. CAREY: No. In other states, they have not yet made that requirement.

MR. TESSIER: It occurs to me that that's an important point you're making to us, for us, and I'm wondering, it seems to me, on the one hand, we've got that concern, the needing to be sure that the Exchange, in addition to the incentives of new business and subsidized business essentially through the Exchange, is a huge incentive for insurance companies.

We need to be careful that, as we try to encourage innovative products and all the rest, then use the Exchange as a vehicle to advance health care reform, that we don't overdo it.

I'm wondering, on the other hand, we also have the enormous needs of consumers, who don't have health insurance coverage today, and need access to meaningful programs, etcetera, I'm wondering, it seems to me those are, in some ways, could be conflicting needs that the Exchange needs to find a way to balance, so I'm wondering if we can, and maybe you're going to get into this, Bob, with the work plan, but I'm wondering if

there's a way to formally bring presentations to this Advisory Board, Advisory Committee, from the industry.

I certainly don't mean to suggest that you did this, but we often hear that as rhetoric. I'd like to know what are the realities? What's real? What appeals to the industry for the Exchange, and what's a burden? Kind of where are the lines? I'd like to hear that.

It might be informative for our deliberations and our advice to the full Board. And maybe the same, by the way, on consumer access and needs, as well.

MR. CAREY: I think you're right, that there is this sort of balance that you need to strike with regard to promoting innovative plan designs, and having information available to consumers, making an informed choice, a lot of competition, based on all of the things that we discussed previously.

The biggest issue from my conversations with insurers, which I have, you know, all the time I speak with insurers across the country, is, you know, is it administratively -- is the "administrative burden," quote, unquote, such that it's, vis-à-vis the potential membership that I will grow, is one worth the tradeoff

versus the other?

So, from my own experience, when we solicited health plans in Massachusetts, there was a requirement, that the health carriers all have carriers with 5,000 or more lives in the individual or small group market, needed to submit a, respond to a solicitation of the connector issue, so this is in the winter of 2006/2007 for plans that will be available in July of 2007.

So all 10 that met that standard needed to submit qualified health plans for the connector's consideration. We wound up selecting seven, one of which said thanks, but no thanks, because they felt that their market share was so small in the State to begin with that it was not worth it for them.

They did the math, and looked at whether it would be worth it for them to participate on the connector, and I think it really came down to, you know, there are other distribution channels.

Now the difference in Massachusetts was there weren't subsidies available on the commercial side. They were two separate programs. So for people on the subsidized side, you know, they wanted to participate, but, on the unsubsidized side, they did a calculation of,

you know, is it worth it for me? I'm going to gain an additional 500 members, 1,000 members, potentially. It's just not worth it if you did the math.

So I think we need to think about it in terms of any requirements that we place on carriers to participate in the Exchange that are above and beyond what is required in the broader marketplace, and that's why we have the Department of Insurance here to help us understand this goes beyond what is required in the marketplace.

We need to be mindful of that. I think that's sort of what I would suggest to the Committee, is that you consider, each time you put a requirement in, it's adding to the list of administrative requirements that would potentially dis-incent a carrier from participating, so we talked about one choice, and provide the consumer with information and so forth and so on. I just wanted to make that point.

There may be, you know, we may want to have carriers come in and talk about their vision of the Exchange. They certainly have visions of the Exchange and how they see it working in the market, so maybe that's something for the Committee to consider.

MR. TESSIER: And I guess I may have left

out we may want, even though we have representation from providers of various sorts, we may also want to consider outreach to the provider community, as well.

MS. O'GARA: Okay. Other items?

MR. CAREY: Okay, so, we'll walk through the timeline and the tasks that we have. The meeting in May, we're going to review. We've gone out to survey the carriers about the products that they offer in the individual and small group market.

We're working with the Department of Insurance to summarize that information, and we thought it would be helpful to come back to the Committee to show you what is commonly purchased in the individual and small group markets today, in terms of the most popular designs, so I thought that would be informative.

Perhaps, most importantly, we'll also have a discussion with regard to the essential health benefits, so for those of you, who aren't immersed in federal regulations and guidance from CMS, they issued, in December, a bulletin to the states, basically deferring to states to determine what constitutes the essential health benefits.

So essential health benefits under the Affordable Care Act are a list of services that must be

included in the benefits package that's offered through the Exchange, what's called a Qualified Health Plan, and they're sort of a, you know, most common types of services provided, inpatient, outpatient, ambulatory care, prescription drugs, mental health and substance abuse, and sort of goes through.

The law directs the Secretary of Health and Human Services to determine what constitutes an Essential Health Benefit Package.

The Secretary of Health and Human Services turned around and said, well, why don't the states figure out on your own what constitutes essential health benefits within the parameters set by the law?

And, so, the bulletin that was issued in December lays out four options for states to consider in setting up what constitutes Essential Health Benefits Package for that state, and, so, we'll go through.

We're going to prepare an issue brief that lays that out for you, that sort of explains, walks you through what the options are, and then we'll have for you a summary of the different benefits packages that are available, so that the four types of benefits packages included in the Essential Health Benefits Bulletin are the three most popular small group plans offered in the

state, the largest HMO plan offered in the state, the Federal Employees Health Benefit Plan, or the State Employees Health Benefit Plan.

Those plans -- the comparison is not on cost share. The comparison is on services covered, and, so, we'll go through -- the cost sharing is taken care of with the Gold, Silver, Platinum, Bronze, in terms of the actuarial value, but the benefits that are covered across those plains have to be the same, and that's what we'll be discussing at the meeting in May, so that will be a pretty intense conversation.

From that, you all will make a recommendation. And, as I mentioned earlier, the Essential Health Benefits Package applies to the broader marketplace in Connecticut. It is not just the Exchange, so it's a bigger decision, I guess, than just an Exchange-focused decision, but the Exchange has a voice, and you will be making a recommendation on what the Essential Health Benefits Package you think should be for Connecticut.

That recommendation will then be brought to other Advisory Committees for them to weigh in, and then brought to the full Exchange Board.

That decision needs to be finalized for

the State of Connecticut by September. If it's not finalized by September, the federal government will make that decision for you, so I think that time is of the essence.

We have the information. We're assembling it now. We'll put together an issue brief prior to the meeting. We'll send that out. We'll be able to read that. Come prepared for the meeting in May to discuss that.

MS. JAFF: Are we also going to tackle the basic health program in May, and, if so, how are we going to do both of those issues in one meeting?

MR. CAREY: So we're not going to do both of those issues in one meeting. I think those are bigger issues. Each one is an issue unto itself.

So the basic health plan we think we'll prepare an issue brief for the June meeting. We can discuss it at the June meeting. The basic health plan, for those of you less familiar with it, the ACA includes an option for states to set up essentially a separate program for individuals with income between 138 and 200 percent of FPL, so subsidies through the Exchange are available between 138 and 400 percent of FPL.

Those below 138 percent of FPL are

eligible for Medicaid, but those between 138 and 200 the ACA provides an option for states to segregate those people, pull those people out of the Exchange, and enroll them in a different health plan with potentially lower cost sharing and potentially lower premiums, so we'll have a discussion about what's the pros and cons and the issues that you'll need to consider in recommending whether the State should establish a basic health program.

So we think that will be ripe for discussion and review and hopefully a recommendation at the June meeting.

DR. McLEAN: When you put that material together, is it possible in a relatively concise way to communicate what other states have done? Not the details of whether they picked one versus the other.

MR. CAREY: Sure. Yeah and, so, they've been, you know, every state is sort of going through, not every state, many states are going through a similar process, so there is information that we'll be able to pull, analyses that were done, for example, on basic health program options for California, and there was an analysis that was done for New York State.

The staff will put together an issue

brief, but we'll have links or appendices that will then allow you, if you want, to read a 40 or 50-page report that New York State put together about the basic health program, or whatever state we find, so we'll be able to do that, as well.

MS. FOX: What does that analysis include? Financial models? Outcomes?

MR. CAREY: So Mercer, as part of its work in the fall of 2011, put together an analysis of the basic health program, so we'll pull information from that report and include, you know, sort of the findings as best as we know it.

One of the problems with making a decision about the basic health program is the feds have not finalized or provided really any guidance, as to a financing mechanism and how the basic health program will be funded by the federal government, so that will be included.

We'll be able to give you a high-level, you know, read of the law, but, you know, the guidance so far has been, you know, to be determined with regard to the basic health program.

MR. TESSIER: When you put the materials together and make the presentation next month, will part

of that also be to discuss -- we're not the only group that will be -- this Advisory Board is not the only group that's going to be considering and making a recommendation on both of those, the Essential Health Benefits Package and the Basic Health Program --

MR. CAREY: Correct.

MR. TESSIER: And unlike most of what this Advisory Group will do, which is advise the Exchange Board on decisions that it will make, the basic health plan decision is not made by the Board, correct?

MR. CAREY: Correct.

MR. TESSIER: I'm not clear about the Essential Health Benefits Package.

MR. CAREY: Correct. Neither one are sort of the sole purview of the Exchange Board, but we feel that the Exchange Board and its Advisory Committee has a role to play in that, and, so, in essence, will be making a recommendation for the Board to then make a recommendation with regard to both of those issues.

I don't know if, Mary Ellen or Anne Melissa, you want to talk about any work that the Department is doing around the Essential Health Benefits or any thinking.

MS. BREAULT: No. I think we agree with

you, Bob, since it really impacts the entire market. My understanding, from discussions and calls with CCIIO, basically, a letter will come to the Governor, and the State will have to make a determination in the fall.

And, so, clearly, it is important for the Board to weigh in, since it does impact the Exchange Board, but there are impacts for the entire commercial market in the State.

And, you know, we have worked with the Exchange staff to put out the survey. CCIIO is still coming out with further guidance on the determinations. They came out last December with some picks. They're going to redo that.

There may be some, based on discussions from other states, there are some discrepancies between their data and what we may find, so we're trying to work through some of those issues, but we will present all of that to the Board.

COURT REPORTER: One moment, please.

MS. O'GARA: Could you provide the English description of CCIIO?

MS. BREAULT: Sure.

MS. O'GARA: So that people, who --

MS. BREAULT: The Department has been

taking calls with CCIIO. That's the -- actually, I'm not even sure what it is.

MR. CAREY: Center for Consumer Information and Insurance Oversight.

MS. BREAULT: They keep changing it. Basically, we will be working with them through the National Association of Insurance Commissioners, and we will bring information back to this Committee for the Board's consideration.

MR. CAREY: Okay, so, those are two minor things. Yes, sir?

MR. FRAYNE: Steve Frayne. I don't know if you'll be able to do it or not, but one of the things I think would be helpful when we get to the basic health plan discussion is, to the extent it's available, if someone could take a look at the eligibility for individuals to enroll in Medicaid versus the eligibility for the State to actually receive subsidies for those individuals if they were in a basic health plan.

My understanding of it could be complete wrong, is that, today, individuals, based on income, can decide to be in Medicaid, even if they work and have access to insurance through an employer, whereas eligibility for subsidies through the Exchange is

dependent upon not having access to affordable, credible insurance, so, you know, there's a lot of discussion about moving populations from one side to another side.

I don't know that there's a good understanding about if you, in fact, move them, would the State actually receive all the funds that people are thinking it might receive, and I think there's some need to understand how one qualifies for Medicaid today versus the ability and availability of subsidy, should that individual wind up with the basic health plan.

MR. CAREY: So there is a prohibition on people, who are eligible for Medicaid, from enrolling in coverage through the Exchange and in the Basic Health Program.

MR. FRAYNE: I'm talking about the folks -- Connecticut currently covers individuals, for example, up to 185 for adults, and they cover pregnant women I think to 250, so there has been talk about perhaps moving those folks out of Medicaid and putting them in the basic health plan.

MR. CAREY: Right.

MR. FRAYNE: There's pros and cons to doing that. The question would be, for the folks that were above the 133 or 138 as stated would they, in fact,

be eligible for subsidies through the basic health plan, if, in fact, they currently work and, in fact, have credible coverage, as defined under the Affordable Care Act, affordable and credible coverage?

It seems like it's a very much human needs question, but it's an important set of needs to get a good answer to, because that can have a dramatic effect on how much resources would be available to the State of Connecticut if they were making choices one way or another.

MR. CAREY: Just so I understand the question, so the question is people, who have access to employer-sponsored insurance, who may also be eligible for Medicaid --

MR. FRAYNE: Today.

MR. CAREY: Today. May choose either employee-sponsored insurance or Medicaid.

MR. FRAYNE: Correct.

MR. CAREY: And the question is, if the State were to offer a basic health program and essentially scale back eligibility for Medicaid, would those people still have that option of choosing either employee-sponsored insurance or the basic health plan?

MR. FRAYNE: Well I think they would have

the choice to choose the employer or the basic. The question would be they would have that choice, but they would not be, the State would, in fact, not be eligible for the subsidy for that individual, because whether they have the basic health plan or not, usually the individual, as I understand it, has to be eligible for the subsidy, meaning you don't have access to employer insurance, it's not affordable, and it's not credible. It doesn't have a sufficient actuarial value.

If you don't meet all three of those requirements, then there's no subsidy for you.

MR. CAREY: Right, through the Exchange, but is the question would there be a subsidy if they were eligible for -- if there was a BHP?

MR. FRAYNE: Correct.

MR. CAREY: Okay.

MS. JAFF: I'm sorry. This is Jennifer. Isn't the BHP funded by the federal government? Isn't that part of one of the huge advantages of the BHP to a state like Connecticut, that could move people from Medicaid to a fully-funded BHP?

I think there are other advantages, as well, but I mean am I missing something?

MR. FRAYNE: The point I'm trying to get

at is, you're correct, they are -- funding does come from the federal government, but the funding is contingent upon being eligible for the subsidy. To be eligible for the subsidy, you have to have no insurance, and you also have to have access to -- you have to not have access to affordable insurance.

So, for example, if I worked in a hospital, and I'm a part-time employee, I would have access to insurance through that hospital. Today, if my income is low enough, I can decide it's too expensive for me. I'd rather get free insurance from the State through the Medicaid program.

As I understand, under the Basic Health Plan Rules, the State wouldn't get a subsidy for me, unless, in fact, the insurance I was getting was, A, too expensive, in other words, it would cost me too much out-of-pocket, and, B, it wasn't credible.

It didn't cover -- you know, an actuarial value I think would be 60 percent, so there might not be a subsidy for me, even though today I'm on Medicaid, because I might, in fact, work someplace, have access to insurance, and seems to be the biases towards employer-sponsored insurance, not necessarily just providing subsidies.

MS. JAFF: I was confused, because we talked about subsidies for the, you know, the advanced premium tax credits also as a subsidy, so I think that's what confused me, was calling the BHP funding a subsidy, but I think now I understand what you're saying.

MS. FOX: This is a really good example, I think, of the level of information this group is going to need, Bob, and, so, you know, if you go for a minute back to the guiding principles, you know, what is the consumer experience here, as they have to make that choice, and then for us to understand the financial model, it says what is it going to cost to the State, you know, what is it going to cost the individual, and how does that all play out? So that was a great question.

MR. CAREY: Okay, so, in June, we'll -- (multiple conversations). So we'll discuss this in detail at the June meeting on the basic health plan.

Also, we'd like the Committee to understand the current process used by the Department of Insurance with regard to the review and approval of benefits and rates, so the Exchange has responsibility for certifying qualified health plans.

Those qualified health plans have to first pass through a filter, known as the Connecticut Insurance

Department, which qualifies the benefit's package and the rates, the rate review and approvals, and we thought it would be helpful for this Committee to understand what's currently done in the State by the Insurance Department, what's the responsibility of the Exchange, and is there a way to leverage, or to defer to, or to work with the Insurance Department in that process?

So folks understand, there will be a universe of plans available in the individual and small group market. The Exchange will sell, offer a subset of those plans.

We'll likely not offer all of the plans. The carriers will likely, you know, have plans that are available outside of the Exchange, but there is a process through which all those plans have to first pass through a review and approval of the Department of Insurance, and we thought it would be helpful for this Committee to understand what that process looks like and how the Insurance Department goes through to licensed carriers, products for sale in the individual and small group market. My friend Mary Ellen has a homework assignment.

Also, we'd like to bring to you information about the cost sharing requirements at each level, so the Exchange offers products in essentially

five levels, based on actuarial value.

Actuarial value is essentially what portion of a person's medical expenses are paid for by the plan, meaning, you know, as part of your premiums, and what portion is paid through cost sharing in the form of deductibles and co-pays and co-insurances, so, at each of the tins, Platinum, Gold, Silver, Bronze, and then the catastrophic plans, there's a certain percentage of actuarial value.

So Platinum plans are at 90 percent, meaning that the carrier in the form of the premiums pays for 90 percent, on average, of an individual's care. The individual, through co-payments and co-insurance and deductibles, would pay, on average, 10 percent, and then that goes down to 80/20, 70/30, 60/40, and, so, we'll bring to you sort of a description of that, some examples of the ways in which carriers or cost sharing works across each of those tins, so people have an understanding of the range of options available at each of those cost sharing levels.

And then we'll also discuss, you know, the pros and cons and what other states are doing with regard to how they're approaching the offering of plans and whether there's different ways in which Exchanges are

thinking about this.

Some are thinking the way that Massachusetts does it is that they standardize the cost sharing, so when you go to look at a Bronze plan in Massachusetts, each of the carriers there's no difference, in terms of the cost sharing, so there might be a $500 deductible, and, you know, 20 percent coinsurance, and an out-of-pocket max of, you know, $6,000.

All of the plans are the same. We talked earlier about choice and innovation, and, so, we'll want to weigh, you know, are there ways in which you might standardize some things, and a lot of innovation on other things, or do you simply allow the carriers to, you know, develop the products that they think are attractive to the marketplace, and, so, we'll have that discussion as part of the cost sharing across each of those plan levels.

In July, we'll review options and develop recommendations regarding those plan designs, so we'll review the different cost sharing in June, and then make a recommendation about what specifically the Committee would like to see with regard to plan designs in the individual and small group market, and we'll also talk

about distinctions that may exist between the individual and the small group market, so there are different products available on the individual side versus the small group, and the Committee may want to recommend to the Exchange Board that the Exchange Board offer or allow the carriers to offer different products in the individual market versus the small group market.

And then we'll also make a recommendation on the numbers of plans that we recommend that Exchange allow carriers to offer at each of the tins.

So that's a relatively big chunk of work that we'll need to get through in July. So folks know, so our current thinking with regard to the sequence of events from the solicitation perspective, so essential health benefits needs to be finalized in September.

We're planning on issuing, you know, a Notice of Intent to issue a solicitation in November to develop that solicitation, in terms of what we're asking of the carriers, what type of criteria will be used to select the qualified health plans.

All of that will need to be finalized by the end of 2012. Carriers will have a couple of months to develop and to offer products and determine what types of products they want to offer to the Exchange.

That will take us into, you know, early spring of 2013. The Exchange Board will need to make a decision about what are the products that we're going to offer consumers to purchase in October of 2013.

We'll then need to work with the carriers to get them integrated into the Exchange's enrollment and billing system, and then, you know, hopefully flip the switch on October 1 of 2013 and offer products to consumers in the individual and small group market, so the timing is such that you need to make important decisions in the summer and fall of 2012, in order to allow for sufficient time for carriers to offer their products to the Exchange, to review that offer, and then to begin open enrollment.

And in August of 2012, we'll also talk about pediatric dental benefits, so there's a provision in the law that talks about the requirement for the Exchange to offer pediatric dental benefits either as part of the package of benefits offered through the qualified health plans, or as standalone dental benefits, and we'll go through a discussion of the pros and cons of that, and the committee will make a recommendation on that.

In September, we'll finalize the

certification criteria. How is the Exchange going to determine whether a plan is a qualified health plan and meets certification, and we'll go through the different metrics or criteria that this group wants to set with regard to health plans that will be offered through the Exchange. That will be a recommendation to the Board, and then we'll finalize that and prepare that recommendation for the Exchange Board in September.

So that's the timeline for the next six months or so. There's lots to do, certainly with regard to the essential health benefits and the basic health plan and the certification criteria.

Any questions? Oh, and just so the sequence, so folks understand, you know, how this will roll out, we'll prepare, you know, issue briefs, as appropriate, for the topics, send those out in advance of the meeting, allow people to review and digest those, and then, at the meeting, we'll have a presentation, and we can have a, hopefully, a more informed discussion, since it won't be so brand new to people, who are just showing up for the meeting.

MS. JAFF: Can I just make a suggestion? When we talk about dental benefits, that perhaps we might want to reach out to the Connecticut State Dental

Association and possibly COHIB(phonetic), as well.

MR. CAREY: Yeah. Good idea.

MS. O'GARA: Any other questions for Bob on the work plan?

MR. TESSIER: One quick one, Bob. Did I hear you right? In May, when we were talking about the essential health benefits and the basic health plan, you're going to present materials and information to us, but reviewing discussion and decision at the June meeting. Did I hear that?

MR. CAREY: Yes, sir?

MR. TESSIER: So that's a different --

MS. CINTRON: We were going to move that down.

MS. O'GARA: Yes, Mark?

MR. ESPINOSA: Mark Espinosa. Just to pick brains here, not to be a naysayer, I'm trying to get a lot of information from my organization in Washington. My International Union is very in tune with President Obama and Vice President Biden, and has a lot of meetings and whatnot, so I'm trying to get as much information out of them as I can, and I'm not able to get anything new.

I'm just wondering if -- in fact, tomorrow, I'm attending a conference by my consultant,

that's putting on a seminar in Boston about these very issues.

My question is are there backup plans, you know? What thought, if any, has been given to the fact that things are very touch and go right now, obviously, pending a decision from higher on in June?

Not to say it's all for naught, but I'm just wondering, like, you know, what type of backup plans, because if it's ruled unconstitutional, that's one thing. If it's not and federal funding is hampered by a political agenda after November, I'm just curious about that, the amount of work that's going into this and the preparation of it.

You're talking timelines, and that's fine, and that has to be stuck to. I understand that, but I have not been given any answers yet, in terms of what do you do next? What do we do next?

Do we just wait and see and just go forward, as if?

MR. CAREY: Yeah. I think that that's the strategy. To be honest, we're under such tight timelines. We can't wait for the -- we can't put everything on hold until June and then say go or no go, that there's things that we can do and should do between

now and the Supreme Court ruling.

I guess my thinking is they may toss the individual mandate. I'd be surprised if they toss the whole thing, but, if they do, we'll have to adjust and figure out how to move forward, but I think -- you know, I was in Alabama on Monday. Not a state that is standing up and cheering the health reform law, but they recognize that, you know, we've got to move forward and do things.

If there's a change in the law, then we'll change our approach, but, until that point, I think, you know, the law is the law until it's not anymore. That would be my suggestion, that we not -- yes, it's out there. You can't avoid it.

We had a discussion yesterday about with the Outreach Committee, and our vendor, Mintz & Hoke, was talking about needing to get information out there, and I said, well, I wouldn't want to put out information that, you know, I then I have to correct in June.

And, so, you know, you've got to be careful about what you're telling people. If you tell people, oh, these subsidies are available in January of 2014, and then have to issue a, well, maybe there won't be subsidies available, so my view is we keep moving forward, we adjust as circumstances change.

Maybe we get through June, and then we have to wait until November, and then there will be potential changes in November. So I guess that would be my suggestion to the Committee.

I was also in Washington. CCIIO is moving ahead, as if nothing is going on. Nobody mentioned anything about a Supreme Court case. It's pretty funny the disconnect, you know, a couple of miles down the road they're talking about something, and, yet, they keep moving forward.

MS. FOX: I also would say that, because of the level of commitment, you know, the Lieutenant Governor being Chair of the Board of the Exchange, and indicators from our Governor, that there is recognition of a serious issue of the uninsured in Connecticut, and there's a commitment to solve for that.

It may look different, you know, after June, but --

MS. O'GARA: Okay, so, we have a couple of remaining questions. One is, what do we need to be doing between now and our next meeting, so we're going to talk a little bit about what's the agenda, and then we can talk about the tasks that need to occur.

One of the things that's not on here is

that we will get you these modified principles, so that you'll have a chance to take a look at them.

As is already articulated, information that the basic health plan is not going to be on there. It will be in June. So, primarily, it will be the survey of carriers and the EHP, right?

MR. CAREY: Right.

MS. O'GARA: And those will be out to you well in advance of our next meeting. The next meeting, dates are hard to pick, and we put a date up here. We kind of want to get a feel for the temperature on that.

That would be about a month from today. It's a Wednesday morning. It could be that week, or it could be the following week, is what we learned, right, Tia?

MS. CINTRON: Yes.

MS. O'GARA: So if people could just kind of look at your calendars? I don't know if you want to give us a sense of that now. We're also prepared to send out a Doddle, is what it's called, to find out when we can maximize participation for the next meeting.

MS. CINTRON: One of the groups had some issues with the week of the 7th, so we were talking tentatively about looking at the week of the 14th.

MS. JAFF: The week of the 14th, there were quite a few people on the Consumer Committee, who wouldn't be able to make it, including one of the co-Chairs.

MS. CINTRON: Okay. Yeah. So maybe the most effective way, if this is appropriate, is just to get out a communication, and we'll do our best to see what's convenient for the majority.

Is this time of day reasonable for all of you?

MS. O'GARA: Okay. We have the last thing on the agenda, was public comments, and what we'd like you to do, if you could, is come forward and state your name and come in front of the mike, so we can get you on the transcription.

MR. GREG WILLIAMS: Any mike?

MS. CINTRON: Any mike.

MS. O'GARA: Any mike.

MR. WILLIAMS: Hi. My name is Greg Williams, and I'm a Connecticut resident, and I have a question just about the Mental Health Parity and Addiction Act.

Just so you know where this question is coming from, I worked at the federal government last

summer for SAMHSA on their Health Reform Office, and we worked with CCIIO, and my first job was to figure out what that stood for, but my second job was to survey insurance plans from around the country on the Essential Health Benefit Package.

One of the biggest challenges that work group had to make recommendations to the Secretary was the discrepancy between the Mental Health and Addiction Parity Act and the Essential Health Benefit and what's a typical employer plan.

And just as this group plans to address pediatric and dental provisions in the ACA, I think it's very important for this group to look at not only the HHS bulletin and Mental Health and Addiction Parity Act and how that's been expanded within the ACA, but, also, to understand that typical employer plans and your options that are going to be laid out may not comply with the 2008 federal regulations for Mental Health and Addiction Parity.

And, so, it's a very complex and in the weeds question, but it's very impactful, and it's almost -- it, actually, even at the ACA, has problems. This law still can stand, so, obviously, the State of Connecticut has to address it one way or the other, and I just

thought that, I was wondering how this Committee was going to handle that.

MS. BREAULT: Just to address, that the State of Connecticut does have legislation with regard to Mental Health Parity. We've had it for some years, and it goes well beyond the federal Mental Health Parity Act. We require mandate coverage for Mental Health Services in all markets, individual, small group, large group, and we do have parity as a requirement.

So even, you know, despite what would happen with the federal reform, Connecticut would still require that all fully insured plans currently have that coverage.

MR. WILLIAMS: Does that include substance abuse?

MS. BREAULT: Yes. Absolutely.

MS. O'GARA: Yes, Jennifer?

MS. JAFF: Yes. If I could just say, I mean, there is a huge issue, in terms of enforcement of Mental Health Parity at both the state and federal level, not so much plan design as plan operation and whether things actually get covered and whether the prior authorization procedures are the same and that kind of thing, so I do think it's a tremendously important issue

and one that needs to stay on the table as we look at the EHB.

MS. O'GARA: Thank you. Are there any other comments from the public? Okay. At this point, then, Anne Melissa and Mark, we'll hand it back to you, in terms of we've concluded our agenda, and I think you can ask for adjournment.

MS. DOWLING: Thank you to all of you for setting up this Committee.

MR. ESPINOSA: Very helpful. Thank you.

MS. O'GARA: Thank you, all, for coming.

(Whereupon, the meeting adjourned at 10:54 a.m.)

RE: CONNECTICUT HEALTH INSURANCE EXCHANGE
APRIL 11, 2012

AGENDA